S. No. 2
M—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34187

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 279

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Levering Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Marion 64
(c) City or town Hannibal 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1120 Woodrow ave 4
(If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Mary Ann Coffey
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Female
5. Color or race White
6. (a) Single, ~~widowed, married, divorced~~ 0
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased May (Month) 15 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. 1/2 min.

9. Birthplace Hannibal (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER
12. Name Walter Coffey
13. Birthplace Hull (City, town, or county) Ill 1 (State or foreign country)
MOTHER
14. Maiden name Dorothy Thompson
15. Birthplace Winfield (City, town, or county) Iowa 1 (State or foreign country)
16. (a) Informant Mr. Walter Coffey
(b) Address Hannibal Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Zion Cemetery
18. (a) Signature of funeral director James Donnell
(b) Address Hannibal
19. (a) 9-26-45 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1945 hour 6 minute A M.
21. I hereby certify that I attended the deceased from May 15, 1945, to May 15, 1945
that I last saw her alive on May 15, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature - about 6 mo.	
Due to Prematurity	
Due to ✓	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

159

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature W P Birney (M. D. or other) MD
Address Hannibal Mo Date signed 5/17/45

1394

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed James O'Donnell

Licensed Embalmer No. 2022

P. O. Address Hannibal Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.